JEFFREY B. VAN ORMAN DMD

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Health History

Patient Name: _____

Please check any of the following boxes for conditions you currently have or have a history of having:

◯ Allergies - Hay Fever	◯ Alzheimer's/Dementia	◯ Anemia	◯ Angina
◯ Anxiety	◯ Arthritis	◯ Artificial Joints	◯ Asthma
◯ Blood Disease	◯ Cancer	◯ Chemotherapy	◯ Diabetes Type I
◯ Diabetes Type ll	◯ Dizziness	◯ Emphysema	◯ Epilepsy/Seizures
◯ Excessive Bleeding	◯ Fainting	◯ Glaucoma	◯ Head Injuries
◯ Heart Disease	◯ Heart Murmur	◯ Hemophilia	◯ Hepatitis A
◯ Hepatitis B	◯ Hepatitis C	◯ High Blood Pressure	◯ HIV
◯ Jaundice	◯ kidney disease	◯ Liver Disease	◯ Low Blood Pressure
◯ Mental Disorders	◯ Nervous Disorders	◯ Depression	◯ No EPI
◯ Osteoporosis	◯ Pacemaker	◯ Pregnant- currently	◯ Premed needed
◯ Radiation Treatment	◯ Respiratory Problems	◯ Rheumatic Fever	◯ Rheumatism
◯ Sinus Problems	◯ Stomach Problems	◯ Stroke-TIA	◯ Tuberculosis
◯ Tumors	◯ Ulcers	◯ Venereal Disease	◯ Eating Disorder
◯ Crohn's Disease	◯ Autism	◯ Other _____	

What is the name of your current medical physician?

_____

Please list ANY allergies. If none, please indicate "none" below.

_____

_____

Are you currently or have you ever taken bisphosphonate medications? (for osteoporosis). If yes, please provide medication name, dosage, and approximate year.

_____

Have you ever had surgery? If so, please explain and include dates: _____

_____

_____

Medications prescribed and over the counter. Include dosage and reason for taking.

_____

_____

Please list any applicable health information not listed and/or any details of medical conditions that were listed above. _____

_____

I certify that all of the above information is complete and accurate

Signature: _____Date: _____